

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6276

## CERTIFICATE OF DEATH

Reg. Dist. No. 203

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution? none

## 3. (a) FULL NAME

George Ingraham Clarkson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

Ethel Clarkson

7. Birth date of deceased (mo. day, yr.)

8-21-1884

6. (c) If alive, give age years

8. AGE:

63

Months 10

Days 1

If less than one day hrs. min.

9. Birthplace.....

(Town, county, state)

10. Usual occupation.....

Farm Laborer

11. Industry or business.....

Farmer

12. Name .....

George Clarkson

13. Birthplace.....

Rock Hall, Maryland

14. Maiden name.....

Mary A. Morris

15. Birthplace.....

Rock Hall, Maryland

16. Informant.....

George Clarkson (husband)

Address.....

Rock Hall, Maryland

17. Burial.....

Burial Date thereof July 2, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Shaytown

Location.....

Near Rock Hall, Kent Co. Maryland

18. Funeral director.....

Marvin V. Williamson

Address.....

Chester, Maryland

19. Date reg'd by registrar.....

July 1, 1948

(Date reg'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED

(If newborn infant, give residence of mother)

State..... County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

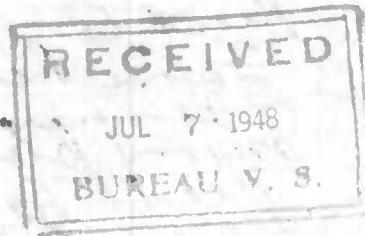
June 29, 1948, at 11:57 P.M.

I CERTIFY that death occurred on the date above stated, that I attended deceased

at his home, Rock Hall, Maryland, and that he died of natural causes.

184-4-8-22

184-4-29  
62-10-7



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6277

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

M

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4.

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married

## 8. (b) Name of husband or wife

Ella Okey 60

7. Birth date of deceased (mo. day yr.)

8. AGE:

Years

Months

Days

If less than one day hrs. min.

## 9. Birthplace

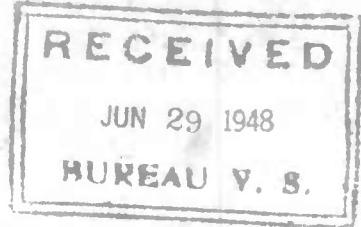
(Town, county, and state)

## 10. Usual occupation

Stock dealer

Fir stock

Cattle



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6278

## CERTIFICATE OF DEATH

Reg. Dlat. No. 2025

1. PLACE OF DEATH: Kent

County.

City or town Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Kent and Queen AnneHow long in hospital or institution? 3 days

## 3. (a) FULL NAME

Serena Farrell

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Colored MarriedCharles Farrell

6. (b) Name of husband or wife

6. (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.)

April 15, 1885

8. AGE:

Years

Months

Days

If less than one day

63

2

13

hrs. min.

9. Birthplace

Queen Anne Co., Maryland  
(Town, county, and state)

10. Usual occupation

Nursing

11. Industry or business

12. Name John Carroll13. Birthplace Mississippi14. Maiden name Moffett Potts15. Birthplace Maryland16. Informant Hosp. RecordsAddress Chestertown, Md17. Burial Burial Date thereof July 3 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or Cemetery Location Baltimore, Md.Location Baltimore, Md.18. Funeral director Edward FellowesAddress Millington, Md.19. Date rec'd by registrar June 29 1948Date rec'd by registrar Clara B. Barnes

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Millington (Rural)  
(If outside city or town limits, write RURAL and give nearest town)Street No.   
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1948 at 2:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1948 to June 28 1948and that I last saw her alive on June 27 1948Immediate cause of death Cerebral hemorrhage DURATION 14 hrs.Due to Hypertension YEARS YearsDue to Other conditions Diabetes mellitus YEARS 1 year?Fibroma uteri (Include pregnancy within 3 months of death) YEARS YearsMajor findings at operations Large fibroma Date of op. 6-26-48

uteri

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A.A. Dick M.D. M. D. or otherAddress Chestertown, Md. Date signed 6-28-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. An incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6279  
93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

## 1. PLACE OF DEATH:

County

Kent

City or town

Chester Town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

14 years

Hospital, institution, or street address where death occurred

Kent and Green Dining Hospital

How long in hospital or institution?

15 days

## 3. (a) FULL NAME

Mabel Thompson Foley

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife

Thomas J. Foley

7. Birth date of deceased (mo., day, yr.)

JANUARY 23, 1889

6. (c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

59 4 15

9. Birthplace

West Elizabeth, Penn.

(Town, County, and State)

10. Usual occupation

Housewife

11. Industry or business

12. Name ..... John Thompson

13. Birthplace ..... England

14. Maiden name

Bell M<sup>c</sup> Vay

15. Birthplace

Penn.

16. Informant

Hosp. Records

Address

Chester Town, Md

17. Burial

Date thereof ..... 6/17/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Chester

Location

Chester, Maryland

18. Funeral director

Marvin V. Williamson

Address

Chester, Maryland

19. Date rec'd by registrar

June 16, 1948

Clara S. Barnes.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... Maryland County ..... Kent

City or town ..... Chester Town

(If outside city or town limits, write RURAL and give nearest town)

Street No. 100 High Street

(If Rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH ..... JUNE 14 1948 at 11:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 31

1948, to

JUNE 14 1948

and that I last saw her alive on

JUNE 14

1948

Immediate cause of death

Peripheral circulatory collapse

Due to ..... Chronic myocarditis

+ arrhythmia fibrillation

Due to ..... anemia decompen.sation

DURATION

20 days

12 mos.

3 mos.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

A. C. Dick, M.D.

M. D. or other

Address ..... Chester Town, Md Date signed ..... 6-15-48

RECEIVED

JUN 18 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6280

## CERTIFICATE OF DEATH

Reg. Dist. No. 201

## 1. PLACE OF DEATH:

County

Kent  
Betterton And

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

6 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mrs Leonora B. Gobes

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Married.

6. (b) Name of husband or wife

Charles J. Gobes

7. Birth date of deceased (mo., day, yr.)

Feb 5 1893

8. (c) If alive, give age ... 58 years

8. AGE:

Years

Months

Days

If less than one day

53

4

11

hrs.

min.

9. Birthplace

Philadelphia Pa

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

Levage cartry

12. Name

Charles J. Gobes

13. Birthplace

Philadelphia Pa

14. Maiden name

Sallie M. Harland

15. Birthplace

Philadelphia Pa

16. Informant

Charles J. Gobes

Address

Betterton And

Burial

Date thereof June 21/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Mt Moriah

Location

Philadelphia Pa

18. Funeral director

B.R. Fellows

Address

Still Pond And

19. Date rec'd by registrar

June 19 1948

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

City or town Betterton And

(If outside city or town limits, write RURAL and give nearest town)

Street No. Avenue And

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1948 at 11:58 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 11 1947 to date 1948

and that I last saw her alive on about 2 weeks ago 1948

Immediate cause of death Cerebral hemorrhage

DURATION

.....

.....

.....

.....

.....

.....

.....

.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE James Edwin Dedman M.D.

M. D. or other

Address P.O. Box 19-Betterton, Md. Date signed June 21 1948

RECEIVED  
JUL 6 1943  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6281

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

## 1. PLACE OF DEATH:

County..... Kent  
City or town..... Chesapeake.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

109 Queen St.

How long in hospital or institution?

## 3. (a) FULL NAME

Warry Childs Hughes

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

Male

White

Widowed

## 6. (b) Name of husband or wife

Mary McMalin Hughes

## 7. Birth date of deceased (mo., day, yr.)

May 10 1872

## 6. (c) If alive, give age

70

years

## 8. AGE:

Years

Months

Days

If less than one day

76 0 28

hrs.

min.

## 9. Birthplace

Smithsburg, Wash. Co. Md.

(Town, county, and state)

## 10. Usual occupation

Dentist

## 11. Industry or business

Willard's Dental Office

## MOTHER FATHER

## 12. Name

Willard's Dental Office

## 13. Birthplace

Wayneboro Pa.

## 14. Maiden name

Barbara A. Pug

## 15. Birthplace

Wayneboro Pa.

## 16. Informant

Mrs. Mary M. Hughes (Wife)

## Address

Chesapeake, Maryland

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.

June 9, 1948

(month) (day) (year)

## Cemetery or crematory

Shore Ridge

## Location

Baltimore Maryland

## 18. Funeral director

Marie J. Williamson

## Address

Chesapeake, Maryland

## 19. Date rec'd by registrar

June 8, 1948

Date signed

Clarice L. Barnes

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Kent

City or town..... Chesapeake

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 109 Queen St.

(If rural, give LOCATION)

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

June 7 1948 at 5:30 PM

I CERTIFY that death occurred on the date above stated; that I attended deceased from

on June 1948, to June 7 1948

and that I last saw her alive on June 7 1948

## Immediate cause of death

Probable coronary thrombosis

DURATION

3 days

Due to Myocarditis

10 years

Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

O. Ruth Barr

M. D. or other

Address Chesapeake, Maryland

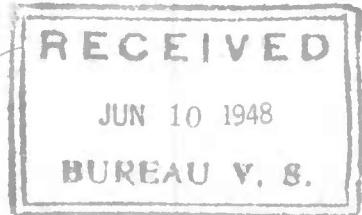
Date signed 6-8-48

Slumbright

1948  
74  

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1872



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6282

203

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....

Kent

City or town.....

Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

life

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Mary Catherine Jacobs

4. Sex

fem

5. Color or race

Wh.

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife.....

Frank Jacobs

6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.)

Sept 30 1890

8. AGE:

Years 57

Months 8

Days 18

If less than one day hrs. min.

9. Birthplace.....

Rock Hall, Md

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

own house

FATHER

12. Name.....

Samuel Thomas Dix

13. Birthplace

Rock Hall, Md

MOTHER

14. Maiden name.....

Annie Virginia Durley

15. Birthplace

Rock Hall, Md

16. Informant.....

Frank Jacobs

Address

Rock Hall, Md

17. Burial

Date thereof June 21-1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Wesley Chapel Cemetery

Location

Rock Hall, Md

18. Funeral director

Edgar L. Lane

Address

Lions Hill, Md

19. Date rec'd by registrar

June 21 1948

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Kent

City or town Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 18

1948 at 7:57 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 6

1948 to June 18 1948

and that I last saw her alive on June 18 1948

Immediate cause of death

cerebral hemorrhage

Paralysis of one side

Due to

Hypertension

Due to

arteriosclerosis

Other conditions

chronic arteritis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

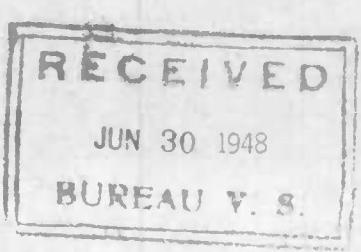
23. SIGNATURE

Albert A. Bergard

M. D. or other

Date signed 6/18/48

Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death clearly and legibly.  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6283

Reg. Dist. No. 2021

## CERTIFICATE OF DEATH

940

## 1. PLACE OF DEATH:

County

Kent

City or town

Chester town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

10 hours

Hospital, institution, or street address where death occurred:

Kent and Queen Anne's Hospital

How long in hospital or institution?

10 hours

## 3. (a) FULL NAME

Walter Clarence Johnson

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White Widowed

## 6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo. day yr)

about 1893

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Johnson City, Tenn.

(Town, county, and state)

## 10. Usual occupation

Farm Laborer

## 11. Industry or business

12. Name

Arthur Johnson

13. Birthplace

Powell, Pennsylvania

14. Maiden name

Robina Drysdale

15. Birthplace

Scotland

16. Informant

Hosp. Records

Address

Chester town, Md.

17. Burial

(Burial, cremation, or removal, which?)

Date thereof June 11-48  
(month) (day) (year)

Cemetery or crematory

Lunch Hill

Location

Lunch Hill Lane

18. Funeral director

John Bell Mif

Address

John Bell Mif

19. Date rec'd by registrar

June 11, 1948

(Date rec'd by registrar)

Clara S. Barnes

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Queen Anne's

City or town Rural - Soldiersville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

JUNE 8

1948 at 11<sup>20</sup> P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JUNE 8

1948 to JUNE 8 1948

and that I last saw him alive on

JUNE 8 1948

Immediate cause of death

Peripheral circulatory collapse

DURATION

18 hours

Due to

MASSIVE CARDIAC INFARCT

Due to

Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

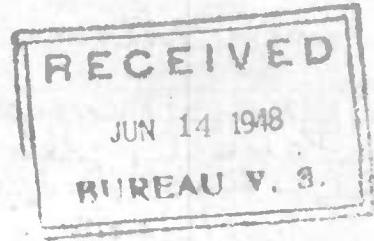
## 23. SIGNATURE

A.C. Dick, M.D.

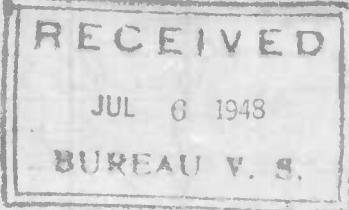
M. D. or other

Address Chester town, Md

Date signed 6-9-48







## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6285

## CERTIFICATE OF DEATH

176  
Reg. Dist. No.

201

## I. PLACE OF DEATH:

County.....

City or town.....

Kent  
Betterton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

3 or less

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

none

## 3. (a) FULL NAME

Joseph Edward Kumpel

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife.....

Vida Kumpel

7. Birth date of

deceased (mo., day, yr.)

June 30, 1901

6.(c) If alive, give age 46 years

8. AGE:

Years

Months

Days

If less than one day

46 11 28

hrs. min.

9. Birthplace.....

Delaware  
(Town, county, and state)

10. Usual occupation.....

Plumber

11. Industry or business

Plumbing

12. Name..... Herman Kumpel

13. Birthplace..... Delaware

14. Maiden name..... Florence Afric

15. Birthplace..... Delaware

16. Informant..... Mrs. Vida Kumpel

Address

Adessa, Delaware

17. Burial

Date thereof..... July 1, 1948  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... Drawyers

Location..... Near Odessa, Delaware

18. Funeral director..... B.R. Fellows

Address..... Still Pond, Md.

19. Date rec'd by registrar..... June 30, 1948

Signature..... J. Melark

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Delaware County.....

City or town..... Odessa

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 2D. DATE OF DEATH

2d. I CERTIFY that death occurred on the date above stated, that I attended deceased from

and held a post mortem examination upon deceased, and made a full report of same to the physician in charge, and that deceased died of the cause reported.

Due to..... Fracture skull

Due to..... Fall

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... hole

Date of op..... no

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill-in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

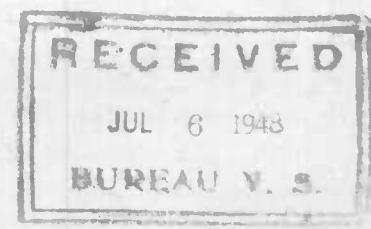
Means of injury..... Fall from dinner

injury at work?

23. SIGNATURE.....

D. or other

Address..... 100 3rd Street, Odessa, Del. Date signed..... June 29, 1948



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6286

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

MARGIN RESERVED FOR BINDING

I

## 1. PLACE OF DEATH:

County Kent

City or town Chestertown, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? now

Hospital, institution, or street address where death occurred:

How long in hospital or institution? now

## 3. (a) FULL NAME

James E. Lowey

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	married

8. (b) Name of husband or wife Elizabeth Bessemer  
living

7. Birth date of deceased (mo., day, yr.) Mar. 12, 1901

8. AGE: Years	Months	Days	If less than one day
47	3	12	hrs. min.

9. Birthplace Hungary  
(Town, county, and state)

10. Usual occupation Office Manager

11. Industry or business Homelite Corp.

12. Name Armin Lowey

13. Birthplace Hungary

14. Maiden name Julia unknown

15. Birthplace Hungary

16. Informant E.H. Stanton

Address Franklin Ave - Nutley, N.J.

17. Burial Date thereof June 28, 1948  
(Burial, cremation, or removal. When?)

Cemetery or crematory East Ridgelawn Cem.

Location Clifton- Passaic Co. - N.J.

18. Funeral director J. Willis Wells

Address Chestertown, Md.

19. June 24, 1948 Clara S. Barnes  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penna. County Lansdowne

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 190 W. Marshall Rd.

(If rural, give LOCATION)

no

2.(a) If veteran, name war.

## 3. (b) Social Security Number

yes

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 24

21. I CERTIFY that it occurred on the date above stated; that I attended deceased from 10 AM until 1 PM. At 1 PM deceased was found dead in his bed. Death was sudden and unexpected. There were no signs of external violence. Death occurred at home. Cause of death was heart attack.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

W

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

W

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

No

Date of

Where did injury occur

none

(City or town)

(County)

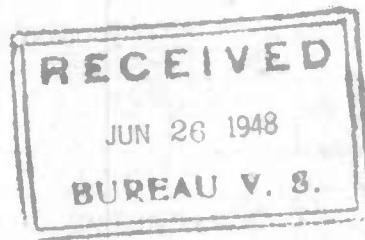
(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?  
Dashed lines to be completed  
by physician  
Signature of physician  
Address  
Date signed

M. D. or other



(I)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6287

## CERTIFICATE OF DEATH

Reg. Dist. No. 938 201

## 1. PLACE OF DEATH:

County

Kent Island

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

7 weeks

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

William T. Lynch

6. (c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.)

May 16 1865

8. AGE:

Years Months Days If less than one day

83 1 13 hrs. min.

9. Birthplace

Georgetown, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Michael Hastings

12. Name

Georgetown, Md.

13. Birthplace

Rachel Hastings

14. Maiden name

Georgetown, Md.

15. Birthplace

William T. Lynch

16. Informant

Lynch Island

Address

Burial Chester

Date thereof July 2 1948

(Burial, cremation, or removal. Which)

Cemetery or crematory Chestertown, Md.

Location

Funeral director B R Fellowes

Address Still Pond, Md.

Date rec'd by registrar July 14 1948

Registrar J. Melark

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

City or town Lynch Island

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH June 29 1948 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1948 to June 1948

and that I last saw her alive on June 28 1948

Immediate cause of death Cardiac

Disease

Tetany. Seizures 1 year

and Delusion.

Due to

Cardiac Disease 5 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

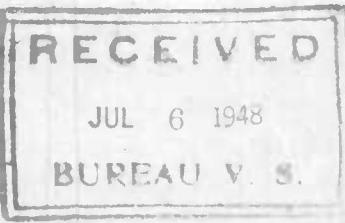
Means of injury Injured at work?

23. SIGNATURE Frank W. Smith

M. D. or other

Address Chestertown, Md.

Date signed June 1948



PLEASE WRITE PLAINLY, WITH UNEADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6288  
938

## CERTIFICATE OF DEATH

Reg. Dist. No. 201

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Elias Theodore Olson

4. Sex

Male

5. Color or race

White, Norwegian

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 20, 1867

8. (c) If alive, give age

78 years

8. AGE: Years

80

Months

11

Days

25

If less than one day

hrs.

min.

9. Birthplace

Delaware

(Town, county, and state)

10. Usual occupation

Farmer

Elias Olson

11. Industry or business

Farmer

12. Name

Elias Olson

13. Birthplace

Delaware

14. Maiden name

Elizabeth Sonoko

15. Birthplace

Delaware

16. Informant

Martha Jackson (wife)

Gandyville, Md.

17. Burial

Burial

Date thereof (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

St. Paul's Cemetery

Location

Edward Yellow

18. Funeral director

Baltimore, Md.

Address

J. Melark

19. Date rec'd by registrar

June 15, 1948

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 14

1948 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 14

1948 to June 14, 1948

and that I last saw him alive on

June 9, 1948

Immediate cause of death

Myocarditis

Duration 24 hours

Due to

Dr. Boris A. Cerasis

W.B. Jr.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

None

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

None

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. or other

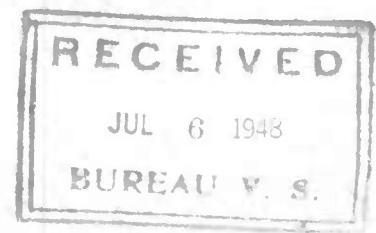
Address

Booth Forman

Date signed

Registrar

Date signed



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6289

## CERTIFICATE OF DEATH

131a  
Reg. Dist. No.

200

## 1. PLACE OF DEATH:

County..... Kent

City or town..... Millington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Clementine V. Pratt

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife

John Pratt

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Aug 11 1874

8. AGE:

Years  
73

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

(Town, county, and state) Del.

10. Usual occupation.....

Housewife

11. Industry or business.....

Obdach

MOTHER FATHER

12. Name.....

Jackell

13. Birthplace.....

Del.

14. Maiden name.....

Anna Goyright

15. Birthplace.....

Del.

16. Informant.....

Mrs. Charles Waring

Address

Millington Md.

17. Burial (Burial, cremation, or removal, where?)

Burial Hartley

Date thereof (month) (day) (year)  
July 21 1948

Cemetery or crematory.....

Hartley

Location.....

Hartley Lef

18. Funeral director.....

Edward T. Fellow

Address

Millington Md.

19. Date rec'd by registrar

July 1 1948 Edward Fellow

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Del.

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town) Towns Chapel

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 28

1948 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 10

1948 to

June 28 1948

and that I last saw her alive on June 28

Immediate cause of death.....

Asthma

DURATION

3 days

Due to.....

Cerebral hemorrhage

4 years

Due to.....

Cerebral hemorrhage

5 yrs

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

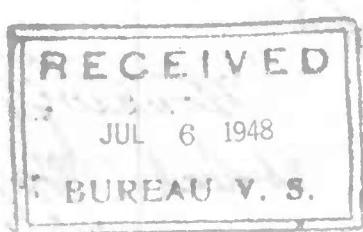
M. D. or other

Address.....

Wilmington

Date signed.....

7/1/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of birth date shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6290

Form No. G 116 JUL 2 1948 CERTIFICATE OF DEATH

Reg. Dist. No. ....

203

1. PLACE OF DEATH: *Kent*

County: *Rock Hall*

City or town: *Rock Hall*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *20 m*

Hospital, institution, or street address where death occurred: *now*

How long in hospital or institution?: *now*

3. (a) FULL NAME

4. Sex: *Male*

5. Color or race: *White*

6. (a) Single, married, widowed, or divorced: *Married*

6. (b) Name of husband or wife: *Henry T. Smith*

Decedent

7. Birth date of deceased (mo., day, yr.): *Sept 21, 1873*

B. (c) M. alive, age: *75* years

8. AGE: *75*

Years: *9*

Months: *2*

Days: *2*

If less than one day

hrs. *0* min. *0*

9. Birthplace: *Washington D.C.*

(Town, county, and state)

10. Usual occupation: *House work*

11. Industry or business: *House*

12. Name: *Henry T. Smith*

13. Birthplace: *Washington*

14. Maiden name: *Elizabeth*

15. Birthplace: *Washington*

16. Informant: *Beth Smith*

Address: *Rock Hall Md*

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof: *June 27, 1948*

(month) (day) (year)

Cemetery or crematory: *Sharptown (Col.) Cem.*

Location: *Rock Hall, Md.*

18. Funeral director: *J. Willis Wells*

Address: *Chestertown, Md.*

19. Date rec'd by registrar: *June 26, 1948*

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: *Maryland*

County: *Wicomico*

City or town: *Rock Hall*

(If outside city or town limits, write RURAL and give nearest town)

Street No.: *now*

(If rural, give LOCATION)

2.(a) If veteran, name war: \_\_\_\_\_

3. (b) Social Security Number: \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: *June 23, 1948*

I CERTIFY that death occurred on the date above stated; that deceased was in good health until \_\_\_\_\_

and that I last saw him alive on \_\_\_\_\_

and immediate cause of death was \_\_\_\_\_

Due to: *Diabetes*

Due to: *Diabetes*

Other conditions: *None*

(Include pregnancy within 8 months of death)

Major findings of operations: *None*

Date of op. \_\_\_\_\_

Autopsy results: *None*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: *No*

Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury: *fall*

Injured at work? *No*

23. SIGNATURE: *R. Elwood Burgess*

M.P. of other \_\_\_\_\_

Address: *Chesapeake, Md.*

Date signed: *June 24, 1948*

RECEIVED  
JUN 30 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. Is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6291

## CERTIFICATE OF DEATH

Reg. Dist. No. 82

202

1. PLACE OF DEATH: Kent  
 County.....  
 City or town..... Chestertown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... life  
 Hospital, institution, or street address where death occurred: High St.  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Kent  
 City or town..... Chestertown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

3. (a) FULL NAME  
 Elizzie M. Corey Smyth

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

8.(b) Name of husband or wife..... Wm. G. Smyth  
 living

8.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1870

8. AGE: Year	Months	Days	If less than one day
78	3	24	hrs. min.

9. Birthplace..... Kent Co. Maryland  
 (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

MOTHER FATHER  
 12. Name..... Albert L. Corey  
 13. Birthplace..... New Hampshire

14. Maiden name..... Sarah C. Smith  
 15. Birthplace..... New Hampshire

16. Informant..... Wm. G. Smyth (Husband)  
 Address..... Chestertown, Md.

17. Burial..... Date thereof June 3, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Paul Cemetery

Location..... near - Chestertown, Md.

18. Funeral director..... J. Willis Wells  
 Address..... Chestertown, Maryland

19. Date rec'd by registrar..... June 1, 1948  
 Address..... Clara S. Barnes  
 Registrar.....

3. (b) Social Security Number  
 no

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 1st 1948 at \_\_\_\_\_

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nobenak 1948 to May 31 1948  
 end that I last saw her alive on May 31 1948

Immediate cause of death..... Accidental

Due to..... Ascending Myelitis 2 days

Due to.....

Other conditions..... Hemiplegia. without speech

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work? .....

23. SIGNATURE..... Frank W. Smith  
 M. D. or other

Address..... Chestertown, Md. Date signed..... June 1/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 203

## 1. PLACE OF DEATH:

County.....

City or town.....

Kent  
Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

life

Hospital, institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution? \_\_\_\_\_

## 3. (a) FULL NAME

Joseph Medford Taylor

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m.

f.

married

B. (b) Name of husband or wife.....

Eva Taylor

B. (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.)

200 Feb 5 1874

8. AGE: Years

Months

Days

If less than one day

74

4

13

hrs.

min.

9. Birthplace.....

Rock Hall, Md.

(Town, county, and state)

10. Usual occupation.....

waterman

11. Industry or business

self

FATHER

12. Name.....

Lawrence M. Taylor

Rock Hall, Md.

13. Birthplace.....

MOTHER

14. Maiden name.....

Mary Eliza Sonney

Rock Hall, Md.

15. Birthplace.....

16. Informant.....

Joseph Medford Taylor

Baltimore, Md.

Address.....

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof June 21, 1948

(month) (day) (year)

Cemetery or crematory

Wesley Chapel Cemetery

Location.....

Rock Hall, Md.

18. Funeral director.....

Edgar L. Lane

Address.....

Christ Church, Md.

19. Date rec'd by registrar

June 21, 1948

(Date rec'd by registrar)

S. Elwood Burgess

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

City or town Rock Hall, Md.

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

June 18 1948 at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

June 13 1948 to June 18 1948

and that I last saw h. m. alive on June 18 1948

Immediate cause of death.....

R. m. spotted fever

Died on

short endo-endo carriage

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury.....

Injured at work? \_\_\_\_\_

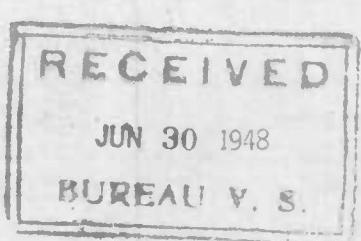
23. SIGNATURE.....

Albert E. Burgess

M. D. *coother*

Address.....

Rock Hall, Md. Date signed 6/18/48



**M**  
PLEASE WRITE PLAINLY WITH UNFADING INK Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6293

830

## CERTIFICATE OF DEATH

Reg. Dist. No. 2102

## 1. PLACE OF DEATH:

County.....

Chester Co.

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

all day

Hospital, institution, or street address where death occurred:.....

202 Synderby St.

How long in hospital or institution?.....

## 3. (a) FULL NAME

Mary Eliza Tilghman

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Col.

Widowed

6. (b) Name of husband or wife.....

(late) Perry Tilghman

7. Birth date of deceased (mo., day, yr.)

April 2 1852

6. (c) If alive, give age ..... years

8. AGE:

Years  
96Months  
2Days  
17

If less than one day

hrs.

min.

9. Birthplace.....

Quaker Kirk, Kent Co., Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business.....

Home

MOTHER FATHER

12. Name.....

Lewis Wm.

13. Birthplace.....

Quaker Kirk, Kent Co., Md.

14. Maiden name.....

Mary Evans

15. Birthplace.....

Kent Co., Maryland

16. Informant.....

Sister Tilghman

Address

Chester Co., Md.

17. Burial

Date thereof.....

June 22 1948

(Burial, cremation, or removal. When?)

Cemetery or crematory.....

Chester Co.

Location.....

Chester Co., Maryland

18. Funeral director.....

Marvin V. Williams

Address

Chester Co., Maryland

19. June 22 1948

(Date rec'd by registrar)

Clara S. Barnes,

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County.....

Kent

City or town.....

Chester Co.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

202 Synderby St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

June 19

1948

12:00 m<sup>ed</sup>

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-19 1948 to 6-19 1948

and that I last saw her alive on 6-19 1948

1948

Immediate cause of death.....

Cerebral Hemorrhage

DURATION

7 hours

Due to..... Arterial Hypertension

unconscious

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE.....

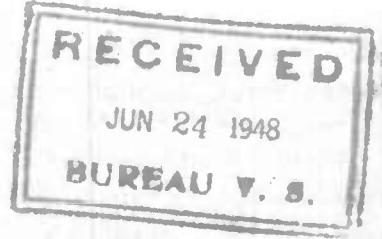
Robert Warr

M. D. or other

Address.....

Chester Co., Md.

Date signed. 6-21-48



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6294

## CERTIFICATE OF DEATH

Reg. Dist. No. 203

932

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white Married

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years      Months      Days      If less than one day  
8      3      0      hrs.      min.

## 9. Birthplace

(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

MOTHER FATHER

12. Name

## 13. Birthplace

## 14. Maiden name

## 15. Birthplace

## 16. Informant

Address

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof June 24-48  
(month) (day) (year)

Cemetery or crematory

## Location

## 18. Funeral director

Address

## 19. Date rec'd by registrar

June 24 1948 8 Elwood Burgess  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

I certify that death occurred on the date above stated; that I attended deceased  
and that I last saw him alive on  
and died of \_\_\_\_\_ cause of death

## Due to

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

## Means of injury

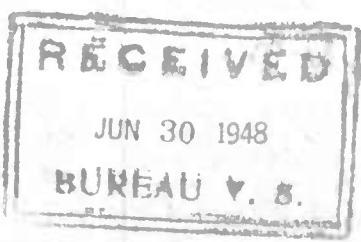
Injured at work?

## 23. SIGNATURE

Address

M. D. or other

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6295

93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 203

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Kent

Rock Hall Rural

How long in above place of death?.....

7 years

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Howard Lloyd Wondery

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

m.

f.

married

6.(b) Name of husband or wife.....

Eunice Wondery

7. Birth date of deceased (mo., day, yr.)

Nov 2 1869

6. (c) If alive, give age ..... years

8. AGE:

Years

Months

Days

If less than one day

78

7

20

hrs.

min.

9. Birthplace.....

Baltimore Md

(Town, county, and state)

10. Usual occupation.....

Retired

11. Industry or business

Western Union

MOTHER FATHER

12. Name.....

Joseph J. Wondery

13. Birthplace.....

Pennsylvania

14. Maiden name.....

Lacy Lloyd

15. Birthplace.....

England

16. Informant.....

Mrs Eunice Wondery

Address

Rock Hall Md.

17. Burial

Date thereof..... June 25 48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or cemetery

Wesley Chapel Cemetery

Location.....

Rock Hall Md

18. Funeral director.....

Edgar L. Lane

Address

Bluff Hill Md

19. June 23 1948

(Date rec'd by registrar)

S. Edward Burgess  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

Kent

City or town.....

Rock Hall Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Deubiegh

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

June 22

1948

al 72017 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 20 1948 to June 22 1948

and that I last saw h. in alive on

6-15

1948

Immediate cause of death.....

chronic respiratory  
arteriosclerosis

Due to..... hypertension

protection, constipation

Due to.....

severe dementia

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

1

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Albert G. Burgard  
M. D. brother

Address.....

Rock Hall, Md Date signed 6/22/48

